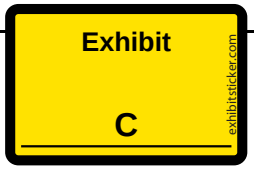
Exhibit C to Complaint

U.S. ex rel. Roark, et al. v. Medical University of South Carolina, et. al.

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A

	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1	DRG amounts other than outlier payments			1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			1.04
2	Outlier payments for discharges (see instructions)			2
2.01	Outlier reconciliation amount			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			2.02
2.03	*Outlier payments for discharges occurring prior to October 1 (see instructions)*			*2.03*
2.04	*Outlier payments for discharges occurring on or after October 1 (see instructions)*			*2.04*
3	Managed care simulated payments			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)			4
	Indirect Medical Education Adjustment Calculation for Hospitals			
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			5
6	FTE count for allopathic and osteopathic programs *that* meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			6
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)			7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)			8.02
9	Sum of lines 5 plus 6, minus lines 7 and 7.01, plus/minus line 8, plus lines 8.01 and 8.02 (see instructions)			9
10	FTE count for allopathic and osteopathic programs in the current year from your records			10
11	FTE count for residents in dental and podiatric programs			11
12	Current year allowable FTE (see instructions)			12
13	Total allowable FTE count for the prior year			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.			14
15	Sum of lines 12 through 14 divided by 3			15
16	Adjustment for residents in initial years of the program			16
17	Adjustment for residents displaced by program or hospital closure			17
18	Adjusted rolling average FTE count			18
19	Current year resident to bed ratio (line 18 divided by line 4)			19
20	Prior year resident to bed ratio (see instructions)			20
21	Enter the lesser of lines 19 or 20 (see instructions)			21
22	IME payment adjustment (see instructions)			22
22.01	IME payment adjustment - Managed Care (see instructions)			22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA			
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			23
24	IME FTE resident count over cap (see instructions)			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			25
26	Resident to bed ratio (divide line 25 by line 4)			26
27	IME payments adjustment factor (see instructions)			27
28	IME add-on adjustment amount (see instructions)			28
28.01	IME add-on adjustment amount - Managed Care (see instructions)			28.01
29	Total IME payment (sum of lines 22 and 28)			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			29.01
	Disproportionate Share Adjustment			
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			30
31	Percentage of Medicaid patient days to total patient days (see instructions)			31
32	Sum of lines 30 and 31			32
33	Allowable disproportionate share percentage (see instructions)			33
34	Disproportionate share adjustment (see instructions)			34
	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	Total uncompensated care amount (see instructions)			35
35.01	Factor 3 (see instructions)			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			35.03
35.04	Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions)			35.04
35.05	Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions)			35.05
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)			
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see instructions)			41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)			44
45	Average weekly cost for dialysis treatments (see instructions)			45
46	Total additional payment (line 45 times line 44 times line 41.01)			46
47	Subtotal (see instructions)			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)			48
49	Total payment for inpatient operating costs (see instructions)			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)			51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).			52



CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A (Cont.)

	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS *(Cont.)*			
53	Nursing and allied health managed care payment			53
54	Special add-on payments for new technologies			54
54.01	Islet isolation add-on payment			54.01
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			55
56	Cost of physicians' services in a teaching hospital (see instructions)			56
57	Routine service other pass through costs (from Wkst .D, Pt. III, col. 9, lines 30 through 35)			57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)			58
59	Total (sum of amounts on lines 49 through 58)			59
60	Primary payer payments			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)			61
62	Deductibles billed to program beneficiaries			62
63	Coinsurance billed to program beneficiaries			63
64	Allowable bad debts (see instructions)			64
65	Adjusted reimbursable bad debts (see instructions)			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)			68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)			69
70	Other adjustments (specify) (see instructions)			70
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			70.50
70.87	Demonstration payment adjustment amount before sequestration			70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			70.91
70.92	Bundled Model 1 discount amount (see instructions)			70.92
70.93	HVBP payment adjustment amount (see instructions)			70.93
70.94	HRR adjustment amount (see instructions)			70.94
70.95	Recovery of accelerated depreciation			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)			70.97
70.99	HAC adjustment amount (see instructions)			70.99
71	Amount due provider (see instructions)			71
71.01	Sequestration adjustment (see instructions)			71.01
71.02	Demonstration payment adjustment amount after sequestration			71.02
72	Interim payments			72
73	Tentative settlement (for contractor use only)			73
74	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			75
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90	Operating outlier amount from Wkst. E, Pt. A, line 2, *or sum of 2.03 plus 2.04* (see instructions)			90
91	Capital outlier from Wkst. L, Pt. I, line 2			91
92	Operating outlier reconciliation adjustment amount (see instructions)			92
93	Capital outlier reconciliation adjustment amount (see instructions)			93
94	The rate used to calculate the time value of money (see instructions)			94
95	Time value of money for operating expenses (see instructions)			95
96	Time value of money for capital related expenses (see instructions)			96
	HSP Bonus Payment Amount	Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100
	HVBP Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)			101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102
	HRR Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)			103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200
	Cost Reimbursement			
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201
202	Medicare discharges (see instructions)			202
203	Case-mix adjustment factor (see instructions)			203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204	Medicare target amount			204
205	Case-mix adjusted target amount (line 203 times line 204)			205
206	Medicare inpatient routine cost cap (line 202 times line 205)			206
	Adjustment to Medicare Part A Inpatient Reimbursement			
207	Program reimbursement under the §410A Demonstration (see instructions)			207
208	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208
209	Adjustment to Medicare IPPS payments (see instructions)			209
210	Reserved for future use			210
211	Total adjustment to Medicare IPPS payments (see instructions)			211
	Comparison of PPS versus Cost Reimbursement			
212	Total adjustment to Medicare Part A IPPS payments (from line 211)			212
213	Low-volume adjustment (see instructions)			213
218	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218